Maine Quality Counts
Better Health Care. Better Health.

December 10, 2012

To: MaineCare Redesign Task Force Members

On behalf of Maine Quality Counts (QC), I would like to thank you for your work to identify opportuities for redesigning the MaineCare program in a manner that will maintain high quality and provide cost-effective services to MaineCare beneficiaries. As a Maine-based non-profit organization committed to transforming health and health care for all Maine citizens, QC is committed to working collaboratively with MaineCare to identify positive solutions to the significant challenges the state is facing at this time.

We further appreciate that the Task Force has considered several areas for action within the MaineCare program, and has made a range of recommendations. Given our role and experience in working with primary care practices in the state and serving as co-Convener of the Maine Patient Centered Medical Home (PCMH) Pilot and contractor to MaineCare for support of their Health Homes initiative, we would like to focus our comments on the recommendations that relate specifically to the MaineCare Value Based Purchasing Program and the recommendations regarding an external "Care Management Organization" (CMO) - i.e. Pgs. 33-35 of the report.

- **Value-Based Purchasing Initiatives**: We agree with the recommendations from the Task Force to continue support for the current MaineCare Value-Based Purchasing (VBP) initiatives, including primary care-based care management initiatives such as Patient Centered Medical Homes and associated Community Care Teams that provide additional care management support to the most high-needs patients of primary care practices.

  It should be noted that the PCMH Pilot was launched in 2010 and is just now approaching the end of the initial 3-year demonstration period, with Community Care Teams implemented for the PCMH Pilot practices just earlier this year. It is also important for the Task Force to be aware that the Maine PCMH Pilot is, by design, limited in scope, with only 25 primary care practices from around the state selected for initial participation. We are currently expanding the multi-payer PCMH Pilot to include an additional 50 practices, and also anticipate that an additional 30-40 practices will join the MaineCare Health Homes initiative; however, these practices together will constitute only about 20% of the primary care practices in the state, which means only 20% of all primary care practices in the state are currently (or will soon) receive at least some financial support for developing these enhanced care management structures. While there is growing interest in and support for the PCMH model from the provider community, we recognize that much more support is needed to promote more widespread adoption of these model. It is not clear, therefore, how the recommendation to support the state's VBP efforts could support additional efforts to build primary care-based approaches to improve care and control costs.

  We also support additional components of MaineCare's VBP program, including the Primary Care Provider Incentive Program and the Emergency Department Collaborative Care initiative. Again, we would note that much of the work of these initiatives is relatively early, and more time is needed to allow for the types of intensive system changes that need to occur both to successfully implement and evaluate these programs. It is notable that the state has invested relatively low levels of resource to implement and support these interventions to date, making it somewhat challenging to ensure their successful implementation.

- **Value-Based Purchasing with Care Management Organization**: While we fully support the need to secure adequate resources to support successful implementation of the MaineCare VBP

programs including the need to support programming, provide technical assistance, and management expertise, we are unclear about several aspects related to the proposal to bring in an external "Care Management Organization" to provide this function:

- The report proposes "contracting with a Care Management Organization (CMO) and tying in savings guarantees" to reduce financial risk to the state – i.e. putting the CMO at financial risk for outcomes. If that is the case, it is not clear how the CMO would guarantee these savings. Many external contracted care management (or managed care) organizations that are willing to guarantee savings have historically employed strategies such as reducing provider fees or providing direct care management services to high-cost members. It would be critical for any contracted CMO to instead employ strategies that support existing local provider-based care management structures that the state and other payers have been developing, thus allowing MaineCare to continue aligning its efforts with other payers in the state to build local provider-based care management and VBP structures such as PCMHs, CCTs, Health Homes, and Accountable Communities / Accountable Care Organizations. While it is not clear what type of organization would be appropriate for this role, it will be important for the state to ensure that such an organization and the resources committed to it support the goals of MaineCare and the VBP program, while also further developing local provider-based care management infrastructure.
- Since MaineCare and other payers in the state have encouraged the development of local provider-based care management structures (e.g. practice based nurse care managers within PCMH and Health Home practices, hospital and community based care transition coaches, CCTs), it would be important for any proposed Care Management Organization to structure its "additional care management initiatives" so that they support rather than duplicate or overlap with local care management activities. These support functions could potentially include critical support functions such as facilitating access to meaningful data that will help local providers identify and manage high-risk, high-cost individuals; providing support and incentives for primary care practices that have not yet moved to the PCMH or Health Homes model; or providing education and incentives to MaineCare beneficiaries to become more actively engaged in their role to participate as an engaged health care consumer.

- **Targeted Care Management for Top 20%**: We again support the Task Force recognition that additional efforts are needed to provide enhanced outreach and care management support for the most high-needs, high-cost MaineCare members. That said, we again have several concerns about the recommendation to bring in an outside Care Management Organization to provide services for the top 20% of utilizers for several reasons:
  - As noted above, it is not clear what role such a Care Management Organization would serve relative to services already being provided by existing local provider-based structures such as primary care practice-based care management in PCMH practices and local Community Care Team. It would be important for any Care Management Organization to focus its efforts on supporting further development of the local provider care management infrastructure, and on filling existing gaps in the capacity of the current provider system, rather than competing with it or creating redundant systems of care.
  - The report includes a recommendation for such an external entity to provide "aggressive case and disease management" to these individuals, which again raises questions about how these services would be distinguished from care management services provided by local provider-based organizations, particularly since it is likely that significant resources could be directed away from local provider-based structures to support the costs of contracting with such an external entity.

- To that end, it should be noted that MaineCare and other payers in the state have recently supported the development of local Community Care Teams (CCTS), specifically to provide intensive care management services to the top 5% of high needs, high cost patients receiving care from PCMH practices as part of its Health Homes initiative with the VBP program. MaineCare recently submitted a State Plan Amendment (SPA) to the Centers for Medicare and Medicaid (CMS) for its Health Homes initiative, and has encouraged efforts by Maine provider organizations and health systems to develop this capacity within CCTs to better manage the needs of these high cost members to improve quality and control costs. While these efforts are still in the early phase of development, these local CCTs are reporting impressive successes in terms of providing outreach and enhanced care management services to high cost MaineCare members. Again, it will be critical for any new Care Management Organization to help support these emerging efforts, while also identifying and filling gaps in the local provider care system.
- We also have concerns about the reference to Care Management Organization taking on a more fully capitated model in the context of other local provider-based VBP strategies, particularly if this strategy includes the external Care Management Organization assuming care and risk for the top 20% of patients, as that would likely include many patients already receiving care and care management services from local provider-based care management structures.
- At the same time, we recognize the compelling need for the state to address MaineCare costs, and understand the appeal of contracting with an external organization that is willing to guarantee performance on controlling costs. We understand that any alternative approach would need to include similar opportunities to control costs, and are hopeful that we can identify workable approaches with the Maine provider community that would offer alternative methods for sharing financial risk to help control costs.
- We expect that it would likely take the state a minimum of 12-24 months and considerable resources to develop a process for contracting with an external Care Management Organization. Given that, we have significant concerns that the need to develop this proposal and contracting process could divert internal state resources that would be better used by expanding the state's current VBP initiative to engage more providers for larger impact across the state.

In closing, we applaud the state for its ongoing efforts to develop a set of VBP initiatives that align with local providers and health systems, and with other payers in the state, and look forward to continued opportunities to support those efforts. However, we have significant questions related to the recommendation to bring in an external Care Management Organization as we feel those efforts, and are concerned that those efforts have the potential to seriously threaten the state's VBP investments to date and would need to be implemented in a way that does not detract from the state's efforts to align with other provider and payer-based efforts.

Thank you for this opportunity to provide input, and please feel free to contact me directly if you have questions or would like additional information.

Sincerely,

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